Connecticut Department of Social Services
Making a Difference

Testimony before the Appropriations and Human Services Committees
Roderick L. Bremby, Commissioner
March 28, 2014

Good morning, Senators Bye and Slossberg, Representatives Walker and Abercrombie and distinguished members of the Appropriations and Human Services Committees. My name is Roderick Bremby and I am the Commissioner of the Department of Social Services. I am here before you today to testify on the 1915(c) home and community-based services waiver, Acquired Brain Injury Waiver II application, pursuant to the adopted state budget for FY 2014 and FY 2015.

The Department of Social Services has administered the Acquired Brain Injury (ABI) Medicaid Waiver since 1999. The existing ABI Waiver (ABI Waiver I) provides critical supports that allow over 430 individuals to live in the community by providing a diverse array of services. Under ABI Waiver I, individual care plan spending can be up to 200% of the identified level of care, as long as the overall spending limit remains at or below the alternative institutional costs.

Since the implementation of the waiver, however, the number of Connecticut residents being served has grown significantly. Under the existing waiver standards, it has become a challenge for the state to maintain the federally required cost-neutrality of serving these individuals outside of an institutional setting. This is what initially prompted the state to evaluate the waiver and determine where changes could be made that would still assure access to the necessary services but also maintain critical cost-neutrality. In addition, the legislatively adopted state budget for FY 2014 and FY 2015 assumes significant additional federal revenue as a result of adding individuals who are currently receiving services at 100% state cost onto a Medicaid waiver.

DSS is also seeking to resolve several additional challenges that have been identified:

- there are not enough slots on the current ABI Waiver to accommodate the 49 people who are currently waitlisted for service as of March 7, 2014; it takes more than three years from date of application for a waitlisted person to access services;
- the Department of Mental Health and Addiction Services (DMHAS) is using state funds to support waitlisted individuals who have traumatic brain injuries and often co-occurring behavioral health conditions, but these services would qualify for federal Medicaid matching payments to offset half of those costs if the individuals were placed under a waiver
- current spending per ABI participant is at a very high level – an average of $96,382 per participant per year –and
- the range of services that are currently offered may not meet the individual needs of all participants.

For these reasons and in accordance with the adopted state budget DSS has proposed to:

- retain the current waiver, ABI Waiver I, which will, with no changes, continue to serve all current participants; and
- seek authorization from the federal Centers for Medicare and Medicaid Services (CMS) for an additional waiver, ABI Waiver II.

ABI Waiver II will include all of the same services as are included in ABI Waiver I, except Transitional Living Services. Consistent with CMS guidance, we have not included Transitional Living Services because there has been no utilization of that service under the current waiver. ABI Waiver II will use a lower "cost cap" and will add five new services: Adult Day Health, Consultation Services, Personal Care Assistance (Agency), Recovery Assistant, and Recovery Assistant II.

What the Proposal Before You Achieves:

The creation of a new waiver will allow the state to maintain ABI Waiver I as is. We are proposing NO changes to the existing waiver, meaning there will be NO impact to those currently being served.

The design of ABI waiver II, with a lower cost cap and the addition of lower cost services, will provide greater assurance that the state will maintain cost-neutrality going forward and will help optimize the use of state dollars. In addition, ABI Waiver II is more in line with the other Medicaid waivers that are also serving individuals with complex needs, but at significantly lower individual cost caps than the current ABI Waiver. It should be noted that there are four levels of care under the waiver (nursing facility, ABI/nursing facility, intermediate care facility and chronic disease hospital). At 150%, these levels of care range from $105,000 (nursing facility) to $610,000 (chronic disease hospital). If an individual were to exceed the cost cap of 150%, then the level of care should be reassessed, which would most likely allow the individual to remain on the waiver.

Facts About the ABI Waiver II:

There are several concerns that have been raised regarding the ABI Waiver II application that we wish to address.

1. Wait List:

While the ABI Waiver II will not eliminate the wait list, it will greatly reduce it. The new waiver will reduce the waitlist from 49 to 30 and, as noted in a previous analysis, we estimate that 13 openings will occur each year as a result of yearly attrition. To go further, we would ask that the waiver before you today be amended to allow for 15 additional slots and that $650,000 be added to the budget for FY 2015 to support those slots under the ABI Waiver II. With this change, the implementation of the ABI Waiver II will reduce the wait list from 49 to 15.

There has been concern expressed over the Department "reserving slots" and allowing those individuals who have been on the waitlist for less time to access services. CMS guidance specifically allows states to create reserve capacity within their waivers to provide access to targeted populations on a priority basis.

2. Service Hours for Independent Living Skills Training (ILST):

The 12 hour ILST limit is and has always been spelled out in the provider manual. The 12-hour limit has been a common practice in the field since the inception of the ABI Waiver I. We are not proposing any change from the current policy.

3. Cost-Neutrality Methodology:

Medicaid waiver programs are inherently complex to plan and operate (and explain). Connecticut has long been a national leader in maximizing opportunities for flexibility in serving our residents through approved waivers of federal rules in the Medicaid program. A baseline requirement, however, is meeting the federal cost-neutrality standards.

CMS requires that the state assure that the average per capita expenditure under the specified waiver (community supports and other Medicaid expenses (Factors D and D') during each waiver year not exceed 100% of the average per capita expenditures that would have been made during the same year for the level of care provided in a hospital, nursing facility, or ICF/IID under the State plan had the waiver not been granted (Factors G and G'). For your information, attached is a detailed overview of the methodology utilized to demonstrate cost-neutrality and waiver cost effectiveness methodologies.

In closing, I would like to thank the Committees for your interest in and attention to this important initiative on behalf of Connecticut residents in need of ABI-related services. As noted, our proposal is also based on the imperative of fulfilling provisions of the enacted state budget.

With your consideration and approval of the state's application for ABI Waiver II amended to provide 15 additional slots, we will be well-positioned to: maintain current services to beneficiaries in the existing ABI Waiver I (which is unchanged),; expand services through the launch of ABI Waiver II; and achieve $6 million in federal financial participation to support services to clients of the Department of Mental Health and Addiction Services who are living with acquired brain injury and who are now being served solely with state dollars.

My staff and I would be happy to answer any questions you may have. Thank you.

Overview of Cost-Neutrality and Waiver Cost Effectiveness Methodologies:

The following discussion, while in-depth, attempts to illuminate the process and aspects of cost-neutrality attainment. The key objective of the cost neutrality process is the ability of the state to demonstrate that the community-based costs of serving the individual under the waiver is less than the potential costs for that individual if they were served in an institutional setting appropriate for their level of care needs.

What is known as 'Factor G' represents the institutional service cost "benchmark" under Medicaid home and community-based services waivers. This factor is meant to depict the estimated institutional cost of care for a client if that client did not have access to community-based waiver services and was receiving services in a long-term care facility setting. When combined with Factor G, the cost of acute and related medical services not covered in the long-term care setting, the full Institutional Care benchmark (G+G-prime) serves as the basis for demonstrating cost-neutrality under the waivers. For the waiver services portion of the cost comparison, Factor D represents the cost of waiver services, and Factor D-prime, the cost of acute and related medical services for waiver recipients. The sum of D and D-prime is compared to the sum of G and G-prime to determine cost-effectiveness. When D + D-prime exceeds G+G-prime, states must take corrective action to reduce costs if they wish to maintain the waiver.

It is important to note that the D and D-prime factors are updated through the course of the waiver based on reported actuals, while Factor G and G-prime are established based upon the projections in the original waiver filing. Therefore, Factor G + G-prime are set for the waiver period as filed in the waiver application; Factors D and D-prime are based upon actuals when the cost-effectiveness comparison is calculated and submitted through the annual federal waiver cost-neutrality reports. The primary reporting tool utilized to help project factors for waiver development and in the waiver cost effectiveness reporting to the federal government is known as the "372 report."

Prior ABI Waiver Development and Cost-Effectiveness
In the development of waiver Factor G, the federal government allows for the use of an applicable report or an alternative method that can be clearly defended and supported by data. Traditionally, in our waiver development, we have used the 372 report as our benchmark, as that seems to be the federal preference. This has proven to be an acceptable federal standard and has allowed us a clear, concise, and consistent methodology for determining our Factor G for waiver projection purposes.

We have reviewed our prior ABI waiver development documents to clarify questions surrounding the manner in which the Department calculated its cost-effectiveness "cap," as presented in previous meetings. When the waiver was renewed for the 2007-2011 period, the most recently available 372 report was the Initial 2005 Report. The data contained in that report were utilized as the base for our projections. Outside of a special adjustment done to the NF (nursing facility) level of care to recognize a one-time nursing home assessment/rate add-on, these base costs received a 3.5% increase per year to establish the Factor G for each waiver year. Based upon the client levels at the various levels of care, a weighted average Factor G was calculated. These are the "Institutional Cost as Filed" figures that have been shared by the

Department in discussions regarding the waiver. It is important to note that the reported 372 values do differ from the overall cost caps that are developed for the purpose of determining allowable percentages of care plan costs (i.e., the 200% provision). As has been pointed out, using a 100% equivalent of care plan cost allowable amounts would imply a higher cost-effectiveness level.

The reason for the difference lies in the manner in which costs are presented in the 372 report. The 372 report includes institutional costs per client but also recognizes the average length of stay in each level of care. For example, if a client enters a chronic disease hospital (CDH) level of care but does not stay in that setting for a full year, the 372 report will include those costs for the partial year of services received. The 372 report, by the nature of its construct, adjusts for the length of stay that a client experiences in the institutional setting, resulting in a lower cost effectiveness "benchmark" on a per-client cost basis. In actuality, the 372 report used in the 2007-2011 waiver had an average length of stay for the CDH level of care of less than one-half of the year. While this is the most significant variance of all the categories, this results in a lower cost-effectiveness level than assuming the full cost of care for the full year. In the development of the renewal for ABI Waiver I that we are currently operating under for 2012 through 2016, the same process was used. In that case, the average of the latest three annual 372 reports available at the time was used to establish the base. A 2.5% factor was applied per year to develop the projected yearly Factor G, along with the client-based weighting to develop the combined factor across all levels of care.

Originally, for purposes of developing the waiver amendment, prior to the separate ABI Waiver II application, we continued the approach noted above. Utilizing the 372 report-based approach as a basis for developing the waiver amendment did present challenges from a cost-effectiveness perspective under this methodology.

When the ABI Waiver II was proposed, we reviewed the approach we had taken in regard to the cost-effectiveness calculation and Factor G. Given the high cost of services for clients under DMHAS care, it was difficult to demonstrate cost-neutrality under the 372 report-based methodology we used previously. This led to a review of the federal guidelines for the calculation of Factor G, and the possibility of using a different approach.

As the federal guidelines allow for an alternative method that can clearly be defended and supported by data, we reviewed Factor G in more detail. For ABI Waiver II, we converted to a service cost-per-day basis and assumed that the institutional costs would be borne for the full year, rather than the lower length of stay imbedded in the 372 report. This led to a higher cost-effectiveness threshold which met neutrality standards. It should be noted that this standard is a much closer match to the full cost of care plans at the 100% level.

All cost effectiveness methodologies must be reviewed and approved by CMS. This new methodology, in the opinion of the Department, follows a logical and thought out approach to support the unique mix of participants that this proposed waiver addresses

Acquired Brain Injury Medicaid Waiver

Fact Sheet (updated 3/27/14)

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lower "cost cap" and will add five new services: Adult Day Health, Consultation Services, Personal Care Assistance (Agency), Recovery Assistant, and Recovery Assistant II.

This fact sheet includes the following:

1) a side-by-side comparison of the current and new waivers; and
2) responses to comments and questions posed by beneficiaries and advocates.

Side-By-Side Comparison of the Current and New Waivers:

	Current Waiver	New Waiver
Name	ABI Waiver I	ABI Waiver II
Available Slots		Year 1: 63 Year 2: 138 Year 3: 213 Year 4: 288 Year 5: 363 The above figures are designed to accommodate new participants as well as to reserve capacity for individuals served by Money Follows the Person (MFP) and DMHAS.
Cost Cap	**200% of the cost of institutional care:** $11,600 per month for NF level of care, $22,970/month for ABI/NF level of care, $29,445/month for ICF/IID level of care and $67,668/month for CDH level of care)	**150% of the cost of institutional care:** $8,700 per month for NF level of care $17,228/month for ABI/NF level of care $22,083/month for ICF/IID level of care and $50,751/month for CDH level of care)
Level of Care	NF, ABI/NF, ICF/IID,CDH	NF, ABI/NF, ICF/IID, CDH
Service Array	• ABI Group Day • Case Management • Chore Services • Cognitive Behavioral Programs • Community Living Support Services • Companion • Environmental Modification • Home Delivered Meals • Homemaker • Independent Living Skills Training • Personal Care Assistance (Private) • Personal Emergency Response Systems • Pre-vocational Services • Respite • Specialized Medical Equipment and Supplies • Substance Abuse Programs • Supported Employment • Transportation • Transitional Living Services • Vehicle Modification Services	• ABI Group Day • Case Management • Chore Services • Cognitive Behavioral Programs • Community Living Support Services • Companion • Environmental Modification • Home Delivered Meals • Homemaker • Independent Living Skills Training • Personal Care Assistance (Private) • Personal Emergency Response Systems • Pre-vocational Services • Respite (expanded to include respite **by non-legally liable relatives)** • Specialized Medical Equipment and Supplies • Substance Abuse Programs • Supported Employment • Transportation • Vehicle Modification Services • **Adult Day Health** • **Consultation Services** • **Personal Care Assistance (Agency)** • **Recovery Assistant** • **Recovery Assistant II**

Responses to Comments and Questions by Beneficiaries and Advocates:

Why isn't DSS simply adding new slots to the existing waiver?

DSS strongly agrees with beneficiaries and advocates that Connecticut needs more capacity to serve those with Acquired Brain Injuries. To expand coverage in this tight budget climate, however, it is necessary to do so in a manner that controls costs. DSS heard loud and clear from current participants that they oppose changes to the current waiver. Therefore, we have instead chosen to implement a new waiver with a lower cost cap, but also expanded service array, for new participants.

Will people served by ABI Waiver I experience changes?

No. People served by ABI Waiver I will continue to receive services based on current criteria. As is required by CMS, DSS will carefully assess the "cost neutrality" of the waiver over time. This means that we will continue to confirm that overall costs do not exceed the costs of institutional care. If cost neutrality becomes a problem in the future, we will work closely with participants to assess their care plan needs and to ensure that there is continuity of care. No one will be "forced off of the waiver."

Will ABI Waiver II make it more difficult for individuals with high care needs to be served?

No. ABI Waiver II includes reserve capacity for individuals served by Money Follows the Person, which supports individuals transitioning from nursing facilities to independent living in the community with housing assistance and other services. ABI Waiver II also includes reserve capacity for individuals served by DMHAS. Further, many current participants of ABI Waiver I are being served effectively with care plans that cost much less than 150% of the cost of institutional care.

Is ABI Waiver II shifting away from rehabilitative supports?

No. Both ABI Waiver I and ABI Waiver II maintain a rehabilitative focus. ABI Waiver II includes all of the same services as are included in ABI Waiver I. Further, five new services are being added to accommodate the needs of the many profiles of those who need services: Adult Day Health, Consultation Services, Personal Care Assistance (Agency), Recovery Assistant, and Recovery Assistant II. To clarify, Recovery Assistant is defined as a flexible range of supportive assistance provided face-to-face that provides a rehabilitative approach to enable a participant to maintain a home/apartment, encourages the use of existing natural supports, and fosters involvement in social and community activities. Service activities include: performing household tasks, providing instructive assistance, or cuing to prompt the participant to carry out tasks (e.g., meal preparation; routine household chores, cleaning, laundry, shopping, and bill-paying; and participation in social and recreational activities), and providing supportive companionship. The Recovery Assistant may also provide instruction or cuing to prompt the participant to dress appropriately and perform basic hygiene functions, supportive assistance and supervision of the participant, and short-term relief in the home for a participant who is unable to care for himself/herself when the primary caregiver is absent or in need of relief.

How will DSS ensure that participants receive high quality and consistent service?

DSS will work with the program's fiscal intermediary, Allied, to assess the adequacy of the provider network and to boost provider engagement. DSS will ensure that the provider listing is kept current, and that it is available both online and in print.

Further, DSS will review the feasibility of recommendations made concerning expansion of criminal background check and training requirements. Additionally, DSS will ensure that the current video curriculum is offered on a regular basis and will convene state waiver managers to discuss the feasibility of implementing additional means of providing training.

DSS will conduct quality assurance surveys of both participants and providers and will make summaries of the results of such surveys available to the Advisory Committee. DSS will also seek input from participants, their natural supports and the Advisory Committee on assessment methods and frequency.

Finally, DSS will also formalize means of providing participants with information on the Brain Injury Alliance of Connecticut (BIAC) and other community supports, as well as information on how to report abuse and neglect. While DSS acknowledges comments urging consideration of increases in the rates paid to ABI Waiver providers, due to budget constraints, it is not currently possible for DSS to increase these rates.

How will DSS ensure that it is kept informed by participants and advocates on an ongoing basis?

As noted in the waiver application, DSS will convene an Advisory Committee with representation by participants and advocates. DSS will ensure that the Advisory Committee has the opportunity to review and comment on quality assurance information, assessment method and frequency, Fiscal Intermediary and ABI Waiver Summary reports, and summaries of participant surveys.

How does the cost cap for the ABI Waiver compare to other Medicaid Waiver Programs?

The 200% cost cap for the current ABI Waiver is the highest cost cap of all of the Medicaid waiver programs. The Personal Care Assistance, Elder and Katie Beckett Waivers are all capped at 100% of the cost of institutional care. The Mental Health Waiver is capped at 125%. DDS operates four waivers. The Comprehensive Supports Waiver is capped at 150% of the institutional cost while the Individual and Family Support, Employment and Day Supports, and Autism Waivers are capped at less than 100%. The proposed 150% cost cap for ABI Waiver II brings the cap in line with the highest cost cap of all of the other waivers and provides significant service dollars within that cap.